PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION ____

MR. SPEAKER:

I move that House Bill 1924 be amended to read as follows:

Page 1, between lines 6 and 7, begin a new paragraph and insert:

"SECTION 2. IC 22-3-3-5.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or

deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(4) The billing review standard shall include the billing charges of all hospitals in the applicable community for the service or product.

(b) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; ~~and~~

(4) in the case of a CPT coding change, the basis upon which the change was made; **and**

(5) upon request:

(A) the identity of each hospital whose billing charges were included in the billing review standard used in the course of reviewing the medical service provider's bill; and

(B) written certification from the billing review service that the billing review service complied with subsection (a) in the course of reviewing the medical service provider's bill;

not later than thirty (30) days after the date of the request.

(c) If, after a hearing, the workers compensation board finds that a billing review service:

(1) did not comply with subsection (a) or (b);

(2) under subsection (b)(5)(A) falsely identified the hospitals whose charges were included in the billing review standard used in the course of reviewing a medical service provider's bill; or

(3) under subsection (b)(5)(B) falsely certified compliance with subsection (a);

the workers compensation board may assess a civil penalty against the billing review service that is not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000) for each violation.".

Page 5, after line 22, begin a new paragraph and insert:

"SECTION 4. IC 22-3-7-17.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 17.2. (a) A billing review service shall adhere to the following requirements to determine

the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under this chapter:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(4) The billing review standard shall include the billing charges of all hospitals in the applicable community for the service or product.

(b) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; ~~and~~

(4) in the case of a CPT coding change, the basis upon which the change was made; **and**

(5) upon request:

(A) the identity of each hospital whose billing charges were included in the billing review standard used in the course of reviewing the medical service provider's bill; and

(B) written certification from the billing review service that the billing review service complied with subsection (a) in the course of reviewing the medical service provider's

bill;

not later than thirty (30) days after the date of the request.

(c) If, after a hearing, the workers compensation board finds that a billing review service:

(1) did not comply with subsection (a) or (b);

(2) under subsection (b)(5)(A) falsely identified the hospitals whose charges were included in the billing review standard used in the course of reviewing a medical service provider's bill; or

(3) under subsection (b)(5)(B) falsely certified compliance with subsection (a);

the workers compensation board may assess a civil penalty against the billing review service that is not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000) for each violation.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1924 as printed February 25, 1999.)

_____

Representative Crosby